

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013244

FILED MAY 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2014

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City Missouri	
c. FULL NAME OF (If NOT in hospital, give location) Menorah Medical Center				Length of stay in lb 60 days		d. STREET ADDRESS (If outside, give location) 6140 Morningside	
3. NAME OF DECEASED (Type or print) First Nellie Middle Dale Last Dale				4. DATE OF DEATH Month April Day 20 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-7-81		9. AGE (In years last birthday) 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Lone Jack Mo.	
13a. FATHER'S NAME Jesse M Cave				13b. MOTHER'S MAIDEN NAME Sarah E. Satterfield		14. NAME OF HUSBAND OR WIFE Ambrose Dudley Dale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Elizabeth Ennis 6440 Morningside Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion with myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 1958 to 20 April '59 and last saw her alive on 20 Apr. 1959 Death occurred at 11:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Signed or title) Walter P. Jacob				22b. ADDRESS 701 E 63 St.		22c. DATE SIGNED 4/21/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4 24 59		23c. NAME OF CEMETERY OR CREMATORY D. W. Newcomer's Sons		23d. LOCATION (City, town, or county) Kansas City, Mo	
24. FUNERAL DIRECTOR D W Newcomer son mo		ADDRESS H.C		25. DATE RECD. BY LOCAL REG. 4-22-59		26. REGISTRAR'S SIGNATURE Neva Minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Walter P. Jacob

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Albert F. Savage*

Licensed Embalmer No. *4812*
P. O. Address *Worcester, Mass.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.